



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-10

08429

CERTIFICATE OF DEATH

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County

City or town

Worcester
Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Luisa Birmingham

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Oct. 10 - 1887

6. (c) If alive, give age

years

8. AGE:

Years 57 Months 8 Days 6 It less than one day hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal; Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Date

19. (Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

70

3. (b) Social Security Number

701

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 16 1945 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 22 1944, to Aug. 16 1945
and that I last saw her alive on Aug. 16 1945

Immediate cause of death

cerebral vascular
accidentDue to Hypertensive Cardio-
vascular renal disease 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

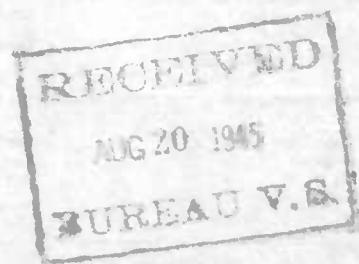
Means of injury

Injured at work?

23. SIGNATURE

Robert L. La Mar, M.D. or other

Address Snow Hill Date signed 8/16/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

68430

CERTIFICATE OF DEATH

357

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Worcester
Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 88 years

(If outside city or town limits, write RURAL and give nearest town)

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

8. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.)

July 31-1867

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

78 0 0 0 hrs. min.

9. Birthplace

Snow Hill Worcester, Md.

(Town, county, and state)

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. Name

Peter D. Collingham

Maryland

13. Birthplace

Elizabeth Parker

Maryland

14. Maiden name

Mrs. Mrs. D. Powell

15. Birthplace

Snow Hill, Md.

16. Informant

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

Worcest. Methodist

Snow Hill, Md.

18. Funeral director

Address

Herman & Dennis

Snow Hill, Md.

19. 8/3 1945

(Date rec'd by registrar)

Lester Smith

Registrar

2. USUAL RESIDENCE, (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 1 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 16 1944 to Aug 1 1945

and that I last saw her alive on Aug 1 1945

Immediate cause of death

Cerebral Vasular Accident

DURATION 1 week

Due to arteriosclerosis & senility

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

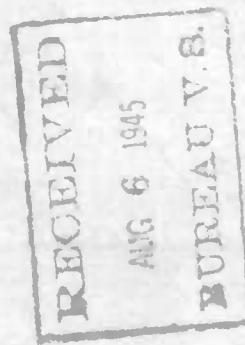
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. La Mar, M.D. or other

Address Snow Hill, Md. Date signed 8/3/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

08431

Reg. Dist. No. 351

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

5 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1945 to August 14, 1945

and that I last saw her alive on August 14, 1945

Immediate cause of death

Abdominal

Inflammation - original

Ruptured + type made hemorrhage

Due to

Considered unserviceable

Primary concerned of uterus

Due to

Duration 12 months

Unknown

DURATION

192

Other conditions

Hypertension + hypertension

Cardio-vascular renal disease

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

08432

350

Reg. Dist. No. 350

1. PLACE OF DEATH:

County WorcesterCity or town Accomac City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bettie Rue Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleColoredWidowed

6. (b) Name of husband or wife

Jacob Johnson

7. Birth date of deceased (mo., day, yr.)

68 years.

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

MaplevilleAccomac Co.Va.

10. Usual occupation

House work

11. Industry or business

None

12. Name

Jessie Washington

13. Birthplace

Va

14. Maiden name

Harrington Savage

15. Birthplace

Va

16. Informant

James Johnson

Address

Accomac City

Burial

Burial

Cemetery or crematory

Shells Hill Cemetery

Location

Rural Accomac Co.

17. Funeral director

Marguerite Delise

Address

Accomac City

18. Registrar

Anne E. White

Address

Accomac City

19. Date rec'd by registrar

Aug. 221945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty WorcesterCity or town Accomac City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

182-0-5155

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 171945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death

accidentally drowned—Due to Falling in grave pit—

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

/PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide accidentDate of Aug. 17 45Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

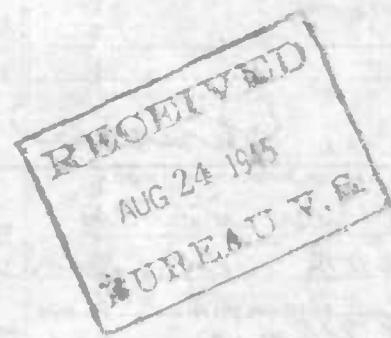
23. SIGNATURE

John L. Riley, M.D. and Exam

M. D. or other

Perowles, Md. Date signed Aug. 18 45

Date signed



M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-301

08433

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

1

2

3

4

5

6

7

8

9

VS A15

1. PLACE OF DEATH:

County..... Worcester

City or town..... Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Richard Perry

4. Sex

5. Color or race

male white married

6. (b) Name of husband or wife..... Harry Perry

7. Birth date of

deceased (mo., day, yr.) Apr. 17 1905

6. (c) If alive, give age 35 years

8. AGE: Years 50 Months 3 Days 27 If less than one day

9. Birthplace..... Bloomington Ind

(Town, county, and state)

10. Usual occupation..... Draft man

Navy Dept

Herman J. Perry

13. Birthplace..... Bloomington Ind

Mark May

15. Birthplace..... Bloomington Ind

Mrs. Richard Perry

16. Informant..... Washington D.C.

Address.....

17. Burial (Burial, cremation, or removal. Which?)

Date thereof..... 8-14-45

(month) (day) (year)

Cemetery or crematory..... Rosehill Cemetery

Location..... Bloomington Ind

18. Funeral director..... Anna A. Burbridge

Address..... Berlin, Md.

19. 8-19 1945 Helen F. Hayward

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town..... Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5108 9th St N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 11

1945 at 4:30 M

19. to 19.

and that I last saw him alive on

Immediate cause of death.....

Myocardial degeneration
of heart

Duration..... few minutes

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

John L. Riley, D.P.M., M.D. or other

Address.....

Date signed..... Aug 11 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08434

CERTIFICATE OF DEATH

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County.....

City or town.....

Worcester

Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 30 years

Hospital, Institution, or street address where death occurred: -

How long in hospital or institution?..... -

3. (a) FULL NAME

Susie Elizabeth Pilchard

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife: -

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

11 less than one day

30 3 26 hrs. min.

9. Birthplace..... Pocomoke, Worcester, Md.

(Town, county, and state)

10. Usual occupation..... Student Nurse

11. Industry or business

12. Name..... Charles Pilchard

13. Birthplace..... Md.

14. Maiden name..... Susan Justice

15. Birthplace..... Md.

16. Informant..... Walter Pilchard

Address..... Pocomoke City Md.

17. Burial..... Cemetery or crematory.....

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Halls Hall Baptist

Location..... Pocomoke City Md.

18. Funeral director..... Marguerite L. D. Dabbs

Address..... Pocomoke City Md.

19. Date received by registrar..... Aug. 24, 1945.

(Date received by registrar) Anne E. White

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Worcester

City or town..... Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 7

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

August 17, 1945, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

1935 to Aug. 16, 1945

and that I last saw her alive on Aug. 16th, 1945

Immediate cause of death.....

O. T.B. of lungs 10 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

P. E. Gastoris

M. D. or

Address..... Pocomoke City Date signed..... 8/24/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-55

CERTIFICATE OF DEATH

Reg. Dist. No. 355

18435
355

1. PLACE OF DEATH: Worcester
 County: Ocean City
 City or town: Ocean City (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME
Maryart John Sheridan

4. Sex: Female 5. Color or race: W 6. (a) Single, married, widowed, or divorced: married

6. (b) Name of husband or wife: Jarrett M. Sheridan7. Birth date of deceased (mo., day, yr.): Oct 28 1890 6. (c) If alive, give age: 55 years

8. AGE: Years: 54 Months: 9 Days: 7 If less than one day: hrs. 00 min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER	12. Name: <u>Henry J. Dohm</u>
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FATHER	13. Birthplace: <u>Baltimore 3rd</u>
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MOTHER	14. Maiden name: <u>Elizabeth Rose</u>
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MOTHER	15. Birthplace: <u>Baltimore, Md.</u>
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16. Informant: <u>Jarrett M. Sheridan</u>

Address: <u>Baltimore, Md.</u>

17. Burial: <u>Burial</u>	Date thereof: <u>Aug 8-1945</u>
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(Burial, cremation, or removal. Which?)	(month) (day) (year)
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Cemetery or crematory: <u>Baltimore Cemetery</u>
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Location: <u>Baltimore City 3d</u>

18. Funeral director: <u>Margaret G. Glavin</u>

Address: <u>Ridemore City 3d</u>

19. (Date rec'd by registrar): <u>8-6</u>	19. (Date of death): <u>Aug 4-1945</u>
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2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Baltimore City: Baltimore
 City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
 Street No. 837 N. Patterson Park Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 5 1945 at 3 a.m.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12 to 19 and that I last saw him alive on 19.Immediate cause of death: Cerebral hemorrhage DURATION 10 min

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE: John L. Riley, D.P. M.S. Exam M. D. or other _____Address: Seawell Ave. Date signed: Aug 5-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *16th*

CERTIFICATE OF DEATH

Reg. Dist. No. *353**08436*

1. PLACE OF DEATH:

County..... *Worcester*
 City or town..... *Bishopville*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Minnie Ann Tubbs*4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Single*7. Birth date of deceased (mo., day, yr.) *Aug 11, 1945*8. AGE: Years *1* Months *0* Days *0* If less than one day *0* hrs. *0* min. *0*9. Birthplace *Maryland* (State, county, and state)

10. Usual occupation.

11. Industry or business *Farming & Chickens*12. Name *Bill Tubbs*13. Birthplace *Maryland*14. Maiden name *Elizabeth Taylor*15. Birthplace *Maryland*16. Informant *Elizabeth Tubbs*Address *Blyerville R.D. 2*17. Burial (Burial, cremation, or removal, which?) *Burial* Date thereof *Aug 13 1945* (month) (day) (year)Cemetery or crematory *St. Martin's Park Church*Location *Bishopville, Md.*18. Funeral director *M. Parker Station*Address *Blyerville, Md.*19. (Date rec'd by registrar) *Aug 15 1945* *Franklin Basye* Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Worcester*
 City or town..... *Bishopville*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

2. (a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 12 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 11 1945 to *Aug 12 1945* and that I last saw her alive on *Aug 12 1945*

Immediate cause of death

Childbirth

DURATION

24 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

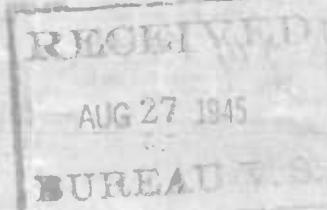
Means of injury

Injured at work?

23. SIGNATURE *Franklin Basye*

M. D. or other

Address *Blyerville, Md.* Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

Reg. Dist. No. 350

08437
350M
✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

1. PLACE OF DEATH:

County. WorcesterCity or town. Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Nora L. Tilghman Wilson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Widowed

6. (b) Name of husband or wife

John Lloyd Wilson

7. Birth date of deceased (mo., day, yr.)

January 16, 1867

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Day

If less than one day

78

6

29

hrs.

min.

B. Birthplace. Pocomoke, Worcester, Md.
(Town, county, and state)10. Usual occupation. Housewife

11. Industry or business

12. Name. George Tilghman

13. Birthplace

14. Maiden name. Sallie Bratten Jones

15. Birthplace

16. Informant. Mrs. Nora BostonAddress. Pocomoke City, Md.

17. Burial

Date there. Aug. 17, 1945
(month) (day) (year)Cemetery or crematory. Salem M. &Location. Pocomoke City, Md.

18. Funeral director.

Address. Marguerite H. Watson

19. Date rec'd by registrar

Date signed. Aug. 17, 1945
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Maryland

County.

WorcesterCity or town. Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)Street No. Clarke Ave

(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH. Aug. 15

1945, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

_____ to _____, 1945, to _____, 1945,

and that I last saw him _____ alive on _____, 1945.

Immediate cause of death. Prostate

Due to.

Due to.

Other conditions.

(Include pregnancy within 8 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of.

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

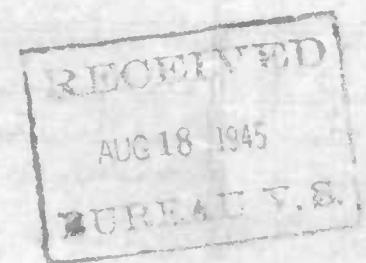
Means of injury

Injured at work?

23. SIGNATURE. R. S. Gilstrap

M. D. or other

Address. 211 Clark AveDate signed. Aug. 17, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Post*

08438

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH
County Worcester
City or town Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Edward Washington Young Jr

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mary Elizabeth Young

7. Birth date of deceased (mo., day, yr.) April 15, 1872

8. AGE: Years 73 Months 4 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Manokin, Somerset, Md
(Town, county, and state)

10. Usual occupation Waterman + Mechanic

11. Industry or business

FATHER 12. Name Samuel James Young
13. Birthplace Md

MOTHER 14. Maiden name Mary Elizabeth Lawrence
15. Birthplace Del

16. Informant Edward W. Young Jr

Address Pocomoke City, Md
Burial Date thereof Aug. 30, 1945
(Burial, cremation, or removal. Which?)

Cemetery or crematory Hall's Hill
Location Pocomoke City

18. Funeral director Marguerite H. Araton
Address Pocomoke City, Md.

19. Aug. 29, 1945 Date rec'd by registrar Aug. 29, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester
City or town Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)

Street No. Cedar (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Aug 27 1945 and that I last saw him alive on Aug 26 1945

Immediate cause of death _____

Sudden collapse DURATION Two

Due to Shower under asbestos 57

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Wilson M. D. Wilson

Address Pocomoke City Date signed Sept. 14, 1945

